



For Immediate Release  
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Contact: Carol Guthrie  
202-224-4515

**Hearing Statement of Senator Max Baucus (D-Mont.)  
Regarding Private Fee-for-Service Plans in Medicare Advantage**

On July 30, 1965, when he signed the law creating Medicare, President Johnson said:

“No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime . . . . And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country.”

Today, we are here again to make sure that Medicare is keeping these promises. We are here to examine the effects of what are called “private fee-for-service” plans in Medicare. And we are here to make sure that these plans are doing their part to keep the promise of Medicare.

People with Medicare have a choice of how to receive their health care benefits. They can receive Medicare through the traditional fee-for-service program. Or they can sign up for what’s called “Medicare Advantage.”

Private health insurers contract with the government on an annual basis to provide Medicare Advantage plans. Insurers receive a monthly payment from Medicare for each beneficiary enrolled.

In 2003, Congress changed the way that private insurers contract with Medicare. And in 2003, Congress also significantly increased Medicare payment rates for private plans.

As a result of these changes – and the way that the administration implemented them – the number of Medicare Advantage plans – and beneficiaries enrolled in them has grown rapidly. Four years ago, only one in ten Medicare beneficiaries got care through a private plan. Today, more than one in every five do.

And this new enrollment in Medicare Advantage is due mostly to growth in “private fee-for-service” plans. In 2005, 200,000 beneficiaries enrolled in these types of plans. Last year, nearly 1.7 million did. That’s a growth rate of nearly 1,000 percent over just two years.

In my home state of Montana, more than 90 percent of all Medicare Advantage enrollees are in private fee-for-service plans, rather than in the health maintenance organizations or preferred provider organization. Most rural areas have similar statistics. Even urban and suburban areas with historically high enrollment in private plans have seen the most explosive growth from new private fee-for-service plans.

These trends far exceed any predictions that Congress received when we passed legislation to create them. We will gather more data on these plans from MedPAC today.

Growth rates like these raise concerns. They require us to take a closer look at what drives them. Last year, Senator Grassley and I decided to do just that.

Here is what we learned: The law gives private fee-for-service plans several allowances that make them easier to get up and running than any other type of Medicare Advantage plan.

First, the law does not require private fee-for-service plans to have relationships with providers to ensure that the providers will serve the people enrolled in the private fee-for-service plans. Doctors and hospitals who do not have a contract with the plan can decide not to treat a patient in one of these plans at any time. And providers can deny treatment even if those providers participate in traditional Medicare.

Second, the law does not require private fee-for-service plans to submit any data about the quality of the care their enrollees receive. That's different from health maintenance organizations or preferred provider organizations.

And the Centers for Medicare and Medicaid Services cannot oversee and regulate the benefits of private fee-for-service plans as they do other Medicare Advantage plans. That means that private fee-for-service plans can require the beneficiary to pay more than traditional Medicare.

In my home state of Montana, providers like the Billings Clinic tell me that they are more than frustrated with private fee-for-service plans. They feel that these plans are burdensome, less transparent, and pay less than traditional Medicare.

Critical access hospitals, like Fallon Medical Complex in Baker, Montana, are especially concerned. The lack of a contractual relationship means that providers have little protection and recourse when these plans underpay or deny care. We will hear more about provider problems from our witnesses today.

Providers in my state also tell me that these private fee-for-service plans are confusing beneficiaries. We will hear more about problems beneficiaries face from our witnesses today.

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Scores of advocates, family members and reporters from across the country have told us about deceptive and abusive marketing tactics used by these private fee-for-service plans. Plans have employed these tactics to enroll seniors and people with disabilities into these plans.

The administration's lax oversight of sales and marketing tactics is another factor that has led to extensive growth in private fee-for-service. We will delve into issues of marketing in Medicare Advantage at a separate hearing in coming weeks.

Today we will take a close look at private fee-for-service. We will look at the real problems with the most rapidly-expanding type of Medicare Advantage plan.

We will consider what we need to do to reform private fee-for-service plans. We will consider whether we need to check their growth. And we will consider whether we can better design the law to ensure that these plans serve the needs of beneficiaries.

We must ensure that Medicare continues to allow older Americans the healing miracle of modern medicine. We must ensure that Medicare continues to protect the savings that they have so carefully put away over a lifetime. And we must ensure that Medicare continues to extend the hand of justice to those who have given a lifetime of service, wisdom and labor to the progress of our country.

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